Stroschein
Dr. Kronberg
2437

IN THE CIRCUIT COURT FOR THE
11TH JUDICIAL CIRCUIT IN AND FOR
DADE COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO. 00-03153 CA 32

SUZETTE A. JANOFF,

Plaintiff,

vs.

COPY

PHILIP MORRIS INCORPORATED,
("PHILIP MORRIS U.S.A."),
R.J. REYNOLDS TOBACCO COMPANY,
LORILLARD TOBACCO CO., and
BROWN & WILLIAMSON TOBACCO CORP.,
Individually and as Successor
to THE AMERICAN TOBACCO COMPANY,

Defendants.
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VOLUME 16

PROCEEDINGS BEFORE THE
HONORABLE LESLIE B. ROTHENBERG
on Tuesday, September 3, 2002
11:00 a.m. to 1:45 p.m.

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# I N D E X



## EXHIBITS

PROCEEDINGS

- - -

THE COURT: Good morning.

Anything we need to address before we bring the jury in?

MR. REILLY: I guess the sequence of events today, Your Honor.

THE COURT: We're going to do this witness and then closing arguments.

MR. REILLY: Great.

We do have one very short section of Dr. Stroschein's testimony that we were going to read. We can either read it before the witness -- that would be fine with me.

THE COURT: That's what I would prefer you do.

MR. WILLIAMS: Your Honor, we -- I guess Mr. Weinstein and I kind of misunderstood the Court. We were under the impression that we would finish the case today and do closing tomorrow.

THE COURT: Absolutely not.

MR. WILLIAMS: There is one issue; we've got to go through the jury instructions and depending on the testimony Dr. Kronberg's

testimony --

THE COURT: It's your fault. You didn't get them to me until this morning, so I'm not going to delay the proceedings. You've each submitted a set to me. I'll rule on them and that will be it. You should have filed them well before today if you wanted additional time. That's the story.

MR. WEINSTEIN: Judge, may I bring up an issue? I know that Mr. Hunter is going to be cross examining their doctor. So may I submit to the court on this issue about bringing up medical text or journals on redirect, most respectfully, judge, I've been doing this for 40 years and I've never, except in this trial --

THE COURT: I don't want to hear what you've never, just give me a rule or case and I'll be happy to entertain it.

MR. WEINSTEIN: Florida evidence 2002 courtroom manual. If I could give it up to the court. And let me just explain why the rule is that way. And I told you originally, I said the Federal Rule is different. Federal they read text directly over and over again to the jury. Florida has this rule, very simple, really. You

can only use medical literature text, et cetera on cross examination if it contradicts the witness.

They can get their favorable text by cross examining our doctors on their cross examination of our doctor. If our doctor states something --

THE COURT: That doesn't make any sense. Let me see the book. Once you attack it and you bring out disfavorable articles, it seems they could then redirect giving other articles. If that's not the case, show me --

MR. WEINSTEIN: They can only address the article that they were confronted with on redirect, judge.

THE COURT: Let me read it.

MR. WEINSTEIN: It can only be used on cross. And it would nullify the rule if it were allowed on redirect to bolster.

MR. UPSHAW: Judge, what rule is he referring to?

THE COURT: 90.706.

MR. REILLY: Your Honor, none of the cases cited stand for the proposition --

THE COURT: Do you have a case that says

otherwise?

MR. REILLY: You know what, Your Honor, not off the top of my head, but we'll take a look for one. But they don't have one that says what they're saying either.

THE COURT: But the general rule says that it can only be used for cross examination. It doesn't then say, but if attacked on cross examination then the plaintiff can then, or the party offering the witness can then introduce contrary evidence.

MR. REILLY: It doesn't address it.

THE COURT: It just says it can only be used during cross examination. So unless you give me a case that says it can be used on redirect if it's impeached on cross examination, then I'm going to rule that you can't do it.

MR. WEINSTEIN: They can refer to the same article, that's it.

THE COURT: Because it's then hearsay.

MR. WEINSTEIN: It would nullify the rule.

THE COURT: Stands for the general proposition. That's going to be the ruling that you can't then ask about other treatises or articles on redirect unless it says you can, if

it's attacked on cross examination.

MR. REILLY: Your Honor, I think we'll read that short portion of Dr. Stroschein first and then bring in Dr. Kronberg.

MR. WILLIAMS: May I hand the Court proposed jury instruction with the case law supporting it?

THE COURT: Yes. This is regarding the what, jury instructions?

MR. WILLIAMS: See, we don't know if it's applicable yet, depending what Dr. Kronberg testifies, but under the line of cases cited -- let me give you some cases.

THE COURT: It appears that you're not agreeing to anything of the Defendants. The Defendants are not agreeing to anything of the Plaintiffs. You each submitted your own set. Is that the way it's going to be?

MR. MOLONY: Your Honor, there are a considerable number of them that are essentially the same. We went to meet this morning, but it unfortunately --

THE COURT: I have a set from the Plaintiff and a set from the Defendant. I take it from giving me each a set from each side, you've

agreed to nothing that either side has submitted. Because I had asked you to do that.

MR. WILLIAMS: I have a set right here where I have objected or agreed to the ones the Defendants submitted.

MR. MOLONY: Your Honor, we will go through theirs and hand up.

THE COURT: I thought you were all going to have this done and on my desk at 9:00. You were going to agree to a set of instructions and those instructions that you did not agree to would be separated and I would have to deal with those. But the way you all handed them to me, I have to go through all the instructions, compare and contrast to see which ones you agree or disagree.

MR. MOLONY: Your Honor, we went to their office at 8:00 this morning. They showed up somewhat later than that.

THE COURT: I told you all to do this Friday because I didn't want to have this problem today.

MR. MOLONY: We exchanged over the weekend, again, several of the claims, at the end of the day. On Friday the Court asked them, what

conditions are you claiming? Well, those conditions have changed over the weekend and they've changed yet again since I've been in this courtroom. That makes it rather difficult for me --

THE COURT: Certainly does.

MR. MOLONY: -- to sign off on -- we've added loss of sense of smell, loss of sense of taste. The verdict form they sent to us over the weekend did not have aggravation of allergy. This morning I got aggravation of allergies back again, Your Honor. So it's a moving target.

MR. WILLIAMS: Judge, that's not the issue. The issue is -- the instructions, the verdict form is quite simple. We just don't agree. What we did is we provided most of the standard instructions. If you look at all theirs, they're not standard.

MR. MOLONY: There are two that are not standard.

THE COURT: I guess I don't want to hear it. I'll look through them, do the best I can with the short period I have.

Let's bring the jury in.

(Jury enters courtroom.)

THE COURT: Thank you, you may be seated.

Let the record reflect presence of counsel for the Plaintiff, counsel for the Defendants and the jury is now present.

Good morning, I think we're ready to proceed.

MR. REILLY: Your Honor, I'd like to begin with a very short reading from the deposition of Dr. Mariel Stroschein.

Mr. Kodsi has been kind enough to answer the few questions that the doctor answered.

This is starting at page 67, line 16:

"Q. Now, you mentioned you have a patient questionnaire.

A. Yes.

Q. Do you ask all your patients whether or not they are exposed to secondhand smoke?

A. Yes.

Q. At least my understanding is that other than Ms. Janoff, you've not concluded that secondhand smoke has caused sinusitis in any of your adult patients?

A. There is nobody that I can think of that I've attributed their problem to this degree to environmental tobacco smoke."

MR. REILLY: No further questions, Your Honor.

At this time we would call our final witness, Dr. Frank Kronberg.

Timing is everything, Your Honor; he just went to the men's room.

Your Honor, not to lose this time. At this time we would put into evidence as a Defendants' exhibit the flight logs of Ms. Janoff for October of 1990 and a composite reflecting those flight logs. It's been stipulated to by Plaintiff's counsel.

THE CLERK: Defendants' Exhibit B.

THE COURT: B you said?

THE CLERK: Yes, judge.

(Defendant's Exhibit B was marked in evidence.)

MR. REILLY: Your Honor, Mr. Williams tells me that no one has yet put in her employment records at American Airlines. So we would now submit those as Defendants' Exhibit C.

THE CLERK: Defendants' C in evidence.

(Defendant's Exhibit C was marked in evidence.)

THE COURT: Do you want to see if he's back

yet?

MR. REILLY: While he's taking the witness stand, let me give you the last exhibit. This is a composite of previously admitted exhibits, but it's organized in a concise fashion.

THE COURT: What are they?

MR. REILLY: I've already provided to Plaintiff's counsel.

THE COURT: What are they?

MR. REILLY: These are a limited edition of the employment records and medical records that are already in evidence, but it's for easy access. And this would be Exhibit D.

THE COURT: These are employment and medical records, but they're a composite?

MR. REILLY: In a concise form, right.

THE CLERK: Defendants' D in evidence.

(Defendant's Exhibit D was marked in evidence.)

THE CLERK: Doctor, if you'd stand and raise your right hand.

THEREUPON,

FRANK KRONBERG, M.D.

having been first duly sworn, was examined and testified as follows:

MR. REILLY: Let me do one more thing; those are CT scans.

THE CLERK: Agreed to?

MR. REILLY: Sure.

THE CLERK: Defendants' E, F and G in evidence.

(Defendant's Exhibits E, F, and G were marked in evidence.)

MR. REILLY: Those are CT scans, Your Honor. They're part of the medical records that have already been stipulated to, but they are the scans.

THE COURT: It's E, F and G?

THE CLERK: Yes, in evidence.

THE COURT: These are all CAT scans?

MR. REILLY: Yes, Your Honor.

DIRECT EXAMINATION

BY MR. REILLY:

Q. Sorry for the delay, doctor.

Can you please introduce yourself to the jury?

A. I'm Frank Kronberg. I'm an ENT physician in Dade County.

Q. Dr. Kronberg, you're a medical doctor?

A. Yes, I am.

Q. Let's begin with your medical educational background. Can you tell this jury where you went to medical school?

A. I went to medical school at Albert Einstein College of Medicine in the Bronx, New York from 1976 to 1980.

Q. Graduated in 1980 from medical school?

A. Yes.

Q. After you completed your medical school training, did you engage in an internship or residency?

A. I did one year internship in general surgery, then four years residency in otolaryngology or ENT.

Q. Where did you do your internship?

A. Jackson Memorial Hospital.

Q. Here in Miami?

A. Yes. It's affiliated with the University of Miami School of Medicine.

Q. Can you tell the ladies and gentlemen of the jury what an internship is?

A. Coming out of medical school, you've been through some rotations during your third and fourth year, but you're never really responsible for taking care of patients. And before you go into whatever

specialty you're going to, if you're going into surgical specialty, you can either do one or two years of a general surgery rotation and then go on to your specialty.

When I was coming out of medical school, the programs were two years of general surgery and three years of ENT. And what ended up happening is they sort of changed things and they made it, during my first year of general surgery, one year and four years. And they had an opening. So I was given that opening.

So what you end up doing is you rotate through the emergency room and take care of patients. You're on the transplant service. You're on the heart transplant team. You're on the floor taking care of general surgery patients. We're at the V.A. Hospital. We're at Jackson Memorial Hospital. When I was there we were on every other night. So it was a pretty rigorous program. And we also rotated through the intensive care units, the surgical intensive care unit. The V.A. Hospital and Jackson had two separate type of general surgery programs. There were the -- the programs were people were going on through general surgery and those that were going on to specialties. So we tended to take care of

things that they didn't really want to do, like the amputations and taking care of the nonglorious kind of general surgery type practice.

Then we finished that up and go into our specialty.

Q. When you say go into your specialty, can you tell me, does that mean you went into a residency?

A. Correct. It's considered a residence program when you start to specialize.

Q. And you did the residency program where?

A. Also at Jackson in the ENT department there. It's affiliated with the University of Miami School of Medicine, V.A. Hospital and Jackson. And also the Sylvester Center. It wasn't Sylvester then; I think it was called University Hospital.

Q. Doctor, can you tell us how long the residency program was and what it was in?

A. It was four years of residency. And that was until July of 1985. You start out the first year assisting the other physicians in the clinics and taking care of people. The first year you may get to do tonsils and tubes. And then progressively, by the last year, you're doing the big head and neck cancer and sinus surgery cases.

Q. Doctor, can you describe -- these folks have heard something about otolaryngology, also known as otorhinolaryngology, but can you briefly describe what otolaryngology or otorhinolaryngology is?

A. Otolaryngology -- we don't really call it rhino. Rhino means the nose part. But otolaryngology is really taking care of the medical and surgical diseases of the head and neck area starting pretty much with the clavicle and going up to the top of the head. Occasionally we'll end up assisting the surgeons doing surgery on the brain. Occasionally we'll assist the ophthalmologists with surgery around the eye. But we don't really do surgery around the eyeball. Take care of diseases of the neck, cancer, thyroid problems, carotid problems, which are in this area. Nasal and sinus diseases, both medical treatment and surgical treatment. We take care of ear diseases, simply from mild ear infections or for eustachian dysfunction to mastoidectomies, where the infections go up into the brain.

A lot of people think of ENT doctors as taking care of just common colds. We're in the emergency room almost every other night taking care of nose bleeds, airway obstructions. We're in the

operating room a lot more now than we used to be, because general surgery has given us all their tracheotomies, approaching the pituitary tumors through the nose.

We also do head and neck flaps. We take flaps from the chest and bring them up to the area of the head to fill up defects from surgery, cancer surgery or trauma. We do facial plastic and reconstructive surgery. Many people that are in ENT will go on and do a fellowship in facial plastics. But we're trained to do facelifts and nasal cosmetic surgery. Blepharoplastics or eyelid surgery, remove cancers or benign lesions from the neck or face.

We're also trained in allergy. And a lot of ENT doctors will go on and subspecialize or specialize more in allergy.

There's ENT physicians that will take fellowships and go on and do ear surgery connected with the brain or removing tumors that are connected with the brain and the ear. They'll also put in the cochlear implants so people can hear. Those are all different specialized parts of our specialty.

Mine is really general ENT.

Q. Doctor, let me ask you, are you board-certified?

A. Yes.

Q. What does that mean?

A. Pretty much that you've gone to a program that's recognized by the American Board of Otolaryngology that you've done a certain number of cases, that they review. And then you take a written test. And then if you pass that, you can go on and take an oral examination.

When I was doing it, though, you didn't really have to do the oral examination if you passed the written test outright. But that's changed.

Q. Doctor, are you a member of professional societies?

A. I'm, starting locally, a member of the Greater Miami ENT Society. The American Academy of Otolaryngology Head and Neck Surgery. The American College of Surgeons.

Q. Are you a fellow in that, doctor?

A. Yes.

Q. Are there very many of those?

A. American College of Surgeons, quite a few.

Q. And are there many fellows?

A. Quite a few fellows.

Q. Are you a member of the American Society of Head and Neck Surgery?

A. Yes.

Q. Are you a member of the American College of Surgeons?

A. Yes.

Q. Are you a fellow in that?

A. That's what I just said. The American College of Surgeons there's a lot. The American Academy of Head and Neck Surgeons there's not that many. And I'm a fellow in that, also.

Q. Doctor, can you tell me if you're in private practice here in Miami?

A. Yes.

Q. And tell me where you practice medicine.

A. I practice in the Kendall area, in Coral Gables and in Hialeah.

Q. Are you on staff at any hospitals here in town?

A. Yes.

Q. Which hospitals?

A. Doctors Hospital of Coral Gables, South Miami Hospital, Baptist Hospital, Jackson Memorial South, Palmetto General Hospital. Miami Children's Hospital.

Q. Are you currently in any teaching positions here in town?

A. I'm a clinical instructor at Jackson. But I haven't been getting there much because I'm too bogged down with this stuff and with work in the office.

Q. What is a clinical professor; what does that mean?

A. It's a clinical instructor.

Q. Sorry. What does that mean?

A. It means you'll go over there and help them with their clinics. Sometimes you can go to the OR and help the residents there. Although, with liability the way it is, we don't really do that in our group.

You'll be presented cases at the head and neck conferences, at grand rounds. Residents will call you up and ask you questions. Sometimes they'll come out in the community and visit you if they're interested in going to practice.

Q. Are you the -- what's the name of the ENT group that you practice with?

A. South Florida ENT Associates, PA.

Q. Can you tell the jury how large an organization that is?

A. Up until December, we had 12 ENT physicians in our group. And others merged with us after that

point. And now there's 27 of us.

Q. Is that the largest ENT group in South Florida?

A. Probably in Florida at this point.

Q. Are you the head of it?

A. Unfortunately.

Q. Do you have any positions at any of the hospitals at which you're on staff in terms of otolaryngology?

A. Up until last year, I was the chief of the subsection at Baptist Hospital.

Q. Of otolaryngology?

A. Yes.

Q. Doctor, you've been in private practice now for 17 years?

A. Since 1985.

Q. Do you treat patients who suffer from acute sinusitis, chronic sinusitis, eustachian tube dysfunction?

A. Yes.

Q. How common are those folks in your practice?

A. We see them every day.

Q. Common illness here in Miami?

A. I'd say the most -- the three most common

things that people come into our office with are difficulty breathing through their nose, ear congestion and hearing loss.

Q. And under the category of trouble breathing through the nose, is that where sinusitis and rhinitis and that sort of thing comes in?

A. Sometimes.

Q. So is -- in your practice, is sinusitis, either acute or chronic, the most commonly encountered disease, chronic disease of Americans today?

A. I didn't understand what you said.

Q. Sorry. Is chronic sinusitis or sinusitis the most commonly encountered disease that Americans suffer from today?

A. I'd say that people call it sinusitis, or they come in saying I've got sinusitis. And that's one of the most frequent complaints of people coming in, but they may not necessarily have it until you work them up and find out whether they really do or not. And if you treat them with medications, you find out.

Q. Doctor, can you tell me whether you are frequently involved in medical/legal matters?

A. Yes.

Q. How frequently?

A. It varies. I'll do from three to six reviews a year.

Q. That's not a major part of your practice, is it, doctor?

A. No.

Q. Can you tell me what kinds of cases, medical/legal matters you've been involved in in the past?

A. Well, this one. There have been other environmental tobacco smoke issues that have been brought to me since 2000, or since the year 2000.

I've taken care of, or looked at cases for attorneys dealing with children that have died from neck abscesses or infections on the plaintiff's side to an operating room fire. Also that one happened to be on the plaintiff's side.

On the defense side taking -- let's see. When a patient would come to the emergency room and be triaged and evaluated and sent to the floor and have a problem with let's say airway obstruction, that was on the defense side.

There's another patient that has a misdiagnosed cancer of the nose. That was in Texas.

Q. Doctor, have you been asked to review cases

both for plaintiffs and defendants?

A. Yes.

Q. Have you been asked to review cases that involve medical malpractice?

A. Yes.

Q. Have you been asked to review cases that involve products liability? In other words, where products have been involved? Has that been something you've done in the past?

A. Other than this one, probably not. More workmen's comp cases. But those have been more independent medical examinations in the office, but not really product liability.

Q. Have you ever testified at trial before?

A. Once when I was a resident.

Q. That was 18 years ago, 19 years ago?

A. About.

Q. So this is the second time you've sat in that chair in the courtroom?

A. Yes. And I'm nervous.

Q. Doctor, can you tell us if you've ever been involved in any other tobacco litigation other than this case, or cases involving flight attendants and environmental tobacco smoke?

A. There was a patient of mine that had cancer

of the tongue that I was a treating physician and I was asked by his attorneys to -- have a couple of conferences with them.

Q. And so that was consultation on behalf of plaintiff's counsel in a cigarette case?

A. Yes.

Q. Did you end up giving testimony in that case?

A. No, they didn't want me to.

Q. Doctor, when you -- on those occasions that you've been involved in legal matters, do you charge for your time?

A. Yes.

Q. And what's your hourly rate?

A. It's $400 an hour.

Q. How did you arrive at that dollar amount?

A. Well, up until we had the big group, we were charging $350 an hour for our services, because that's what we figured we ended up taking in in the office in order to meet our overheads and everything. So we just continued that.

And when the other doctors joined us, we voted on what it should be, because we're one big group and it's got to be uniform. There were some people that were charging more, some people that were

charging less. So that's the number we came up with.

It's pretty close to what it costs us or what we would be taking in in the office, or in the operating room.

Q. Is that right? You tried to figure out a dollar amount that would approximate what you would earn if you were --

A. No, that's looking back in retrospect. So we didn't really try to figure it out. It's just a number that was taken and voted on.

Q. All right.

And doctor, whether it's a plaintiff's case or a defense case, what kind of things are you asked to do or do you do in connection with your medical/legal work? Do you look at medical records?

A. Well, review medical records, review depositions. Look at X-rays. Do literature searches, go on the Internet, you know, go to the hospital and get them to do -- pull journals for us. Do a Medline search.

Q. So you may look at literature, you look at the medical records, if you meet with the lawyers?

A. Yes, do that, too.

Q. You do that regardless of whether it's a plaintiff's or a defense case?

A. Yes.

Q. Doctor, can you tell me whether or not in this case you have done all those things? In other words, reviewed medical records and done literature searches?

A. The other thing occasionally we'll do is ask to see the patient. Like an examination of the patient.

Q. Sometimes you do, sometimes you don't?

A. Yes.

Q. How do you decide whether you need to see the patient or not for purposes of a medical/legal matter?

A. Sometimes you can't because the patient is dead. So I mean that's one thing.

If it's -- if we think it will make a difference or if I think it will make a difference in my opinion, I ask sometimes to see the patient. And usually the request is granted.

Q. So you know that you can make that request?

A. Yes.

Q. And if you feel it's necessary, you do?

A. Yes.

Q. Doctor, can you tell me how many environmental tobacco smoke cases you have consulted

on?

A. Prior to this one or including this one?

Q. Including this one, that would be fine.

A. I think it's seven total.

Q. Let's talk about what you've done in connection with this case. Can you tell the jury what you've done in connection with this case?

A. Starting in -- well, I've got to start from the beginning, because that's when I received a telephone call, which is usually either plaintiff's or defense. How it starts, they will call up and say, are you interested in having a conference with us to talk about this type of problem in this?

In this case it was -- I actually got a phone call in about April or May -- I think it was April of 2000 from an attorney with one of the -- defending one of the tobacco companies.

And at first I figure, there's no way I'm going to do anything like this. I mean, I'm an advocate of not smoking my entire life. And I said, well, I'll have a conference with them. I'll talk to them.

I spoke with two women that came into town, I think in April or May of 2000. And they explained that it was about environmental tobacco smoke causing

problems. And that would I be willing to review charts and look and see if this existed.

And I said two things. I said, one is I'd like to think about it and I'd like to do my own Medline search. The other one is I said, you know, I thought back in my practice and I really didn't equate it at all, sinusitis, even to smokers, but let alone environmental tobacco smoke. So I read materials that I had gotten and that I asked the attorneys to send me, because they said they had the stuff. That's what's in a lot of these boxes.

And for six months I reviewed literature. I looked at stuff. I think it totals about 20 hours worth of reading that I did.

And then they sent me a couple cases to look at. Some were involving sinusitis, some involved other things. I don't even remember, because it's been a while.

But concerning this patient I think I first -- I'd have to look at the bills.

Q. Doctor, feel free to look at whatever records you have.

A. I was asked to review records, I think it was the spring of April in 2001 in reference to Ms. Janoff, Mrs. Janoff.

And I reviewed her records and met with Ms. Perry and Mr. Mebane. I don't even remember who they -- Ms. Perry was one of the initial ladies that I had spoken with. And she was an attorney. And I guess Mr. Mebane was an attorney. And I had gotten an initial packet -- what happens is, any time they get records they send them. So I think I had the original records and then nine different addendums come every month or so.

Q. As records are collected, they're forwarded on to you?

A. I guess so. I don't know how they do it, but a company, FirmLogic, does it. I don't know if that's out of the attorney's office or a company that's contacted by them.

So I got those records and I reviewed them. Usually when I have meetings with an attorney, I do it where I tell them what my findings are. And that was for three and a half hours in probably March of 2001.

Q. Doctor, I'm not going to take you through every one of the --

A. I'll give you a general idea of what's happened then. Because I made pretty much a summary of what's happened with this case and the other case

as far as time spent.

Q. Okay.

A. I've spent approximately 15 and a half hours with the attorneys. Half of that time has been educating them on what the diseases are and going over the records and telling them -- actually educating them, showing them the X-rays and telling them about the sinuses, because they really didn't know too much about the sinuses or head and neck anatomy. And it takes us years to do that. And we have neuroradiology conferences where we go through things and to be able to tell what changes are occurring and what's not occurring. Especially when you have 20 films on a given day. So I went over that.

I've gone over the X-rays, the records. I go over the depositions that were done and pretty much tell them, well, this is not right or this is true and this is a misconception, different things.

So those were my -- that was my time with the attorneys.

Medical records and deposition review is -- and this is up until last month I made a list, within the last month I have a separate thing on what I did. But I spent 19 hours on medical records and

deposition reviews.

I spent about seven hours on the literature, research just for this patient, besides what I did prior to that, the six months before.

Reviewed the CT scans with a radiologist for an hour. And then I had a three-hour deposition that was done, I guess the end of July or the beginning of August of this year.

Q. The Plaintiff's lawyers took your deposition for three hours?

A. Yes.

Q. Some time recently?

A. Correct, a couple months ago.

Q. So you had some preparation for that as well, I take it?

A. That was part of the conference with the attorneys.

Q. Okay.

A. And reviewing the records again. What would happen is, I think it was set for trial one or two times before. And they'd say, okay, go through the records, read them again and then four or five months would go by and I'd forget everything I read and I'd have to read it again. And it is a complex record base. She was seen by a lot of physicians.

Q. All right. And did you obtain all the medical records in this case, all the pertinent medical records?

A. Yes.

Q. Do you know if any of the treating doctors ever in the care and treatment of Ms. Janoff got all the medical records that you did?

A. No.

Q. After reviewing all the medical records and looking at the depositions and reviewing the CT scans, the radiography and that sort of thing, did you reach an opinion as to what Ms. Janoff's condition is today?

A. Yes.

Q. And what's your opinion?

A. Today I believe, or I know that she has chronic right maxillary sinusitis.

Q. All right.

Did you have to see Ms. Janoff to make that determination?

A. No.

Q. Is this a patient -- was this one of those patients that you needed to see in order to form the opinions that you have in this case?

A. Well, I would have liked to have seen her

in 1993. But in the year 2001 it didn't matter, because you could tell from the records what she had. And what she had was also confirmed by what Dr. Casiano saw on the examination. And that's what I would have expected to find.

Q. Can you tell us whether or not you have an opinion as to what caused her present chronic sinusitis?

A. Yes, I do have an opinion.

Q. Could you tell the jury what it is?

A. I think it's a combination of allergic rhinitis, reoccurring upper respiratory infections, but most importantly and something that -- that's hard to really explain why, is that I feel it's secondary to the first surgery that was done in 1993.

Q. Well, we'll talk about your opinions in that regard in detail in just a minute.

A. Okay, but what I mean is scarring from the surgery and different things.

Q. The normal sequela -- sequela is a big word. The complications that can result from sinus surgery like that was performed in 1993?

A. Correct.

Q. Doctor, this jury has heard a bit about the sinuses, but I think it might be helpful for a

complete explanation of your opinions.

If you could step down and very briefly explain to the jury -- and I've brought a couple of demonstratives.

You can pick what would be most helpful in describing the sinuses, how they work.

A. They're both helpful because they both show different things. One is a view -- this view with the face cut this way. And that goes through the sinuses pretty much at this level right here.

And then the other one is --

Q. Here, why don't I put this up -- which one would you like on an easel?

A. We can put both. But this one is cut straight down the head right here.

I'll explain a little about the sinus. I don't know what you've been told or anything, but we've progressed to the point where our sinuses were made developmentally or through time, man has gone from walking on all fours to standing up. And that's one of the reasons that the sinuses drain upward, through evolutionary patterns.

So what happens is that there's four sets of sinuses. There's the sphenoid, which is the sinus that's pretty much in the middle of your head. And

it drains straight into the back of the nose by the nasopharynx. And it can be blocked by the adenoid or the back of the middle turbinates.

You have maxillary sinuses, which drain into the nose and can be blocked in this area by the septum here, which could be crooked. Or this is the middle turbinate and this is the inferior turbinate. If the inferior turbinate gets swollen, if the middle turbinate gets crushed down here --

Q. Do you need a marker?

A. -- from surgery or if there's a deviation of the septum pushing on the middle turbinate. The frontal sinuses are in your forehead and they drain straight down into your nose. And the ethmoid sinuses, it's like a honeycomb area right in the middle between your eyes and the upper parts of your nose.

Q. Doctor, if we put our hands on our face, can we feel these things?

A. Well, you can't feel the sinuses. You can feel the tissue that's overlying the bone that's covering the front part of the sinus.

This is the maxillary sinus in this area. Sometimes -- well, I'm not going to go into the disease of it.

Q. Just explain where it is.

A. This is the maxillary sinus in this area. This is the ethmoid sinus in this area right here. The frontal sinus up here. And usually people that have sphenoid sinus problems have pain in the top of their head.

Q. You said that through evolution --

A. Well, what I meant to say is that there's really two reasons that man has survived with sinus, one is it makes your head lighter because it's supposed to be full of air. And number two, when cavemen used to get hit in the head, the sinuses would break the fracture from going into your brain. So that's what the sinuses are good for.

About 10 percent of people don't have frontal sinuses, so maybe they're slower along the way.

But that's pretty much the sinus disease.

Q. You indicated that the right maxillary and the left maxillary sinuses drain upward; is that right?

A. Right. You can see -- well, you can't really see on this one, but underneath this middle turbinate is where the drainage occurs. So the floor of the sinus is right about here on the side of the

nose. And it's got to come up like this to drain into this area.

So what you do is you have cells that have little cilia on it. And then they beat. And the cilia are within a fluid. And on top of that fluid is another fluid. So what happens is if anything gets trapped here or goes up into this area, the ciliary beat and they push it out to the side, this area.

That's why years ago, I'm going to say when I very first started my general surgery rotation, all the antrostomies into the sinuses used to be underneath the inferior turbinate. And then actually it was, I think physicians in Germany figured out the ciliary flow, that this is the right area to put the opening, because people -- even with an opening down here -- used to get recurrent sinus problems.

So it started making them up here and eventually got to the endoscopic sinus surgery, which I don't know if you want me to go into, but that opens up in this area, that you can do minimal surgery so you don't damage as much tissue.

Q. Doctor, this has been marked as the ostium; is that right? This jury has heard about the ostium. I don't know that they really understand where it is

or what its function is at this moment. But is the ostium, the opening through which the mucus flows out of the sinus?

A. Well, ostium is the opening, it's the opening from the sinus into the nasal cavity. Think of it as like an hourglass. And if you have that hourglass clogged, things can't go. If it's open, it drains through that ostium into the nasal cavity.

Q. Can you show the jury on this chart where it comes out?

A. It comes out in here -- oh, by the way, that's not an opening to the sinus, that's the opening to the ear. This is the eustachian tube.

I don't know if we'll get into the problem with that. But this area can also block up. And that's when the kids come in or adults come in with ear problems.

But this stuff will drain from out of the middle turbinate, if the opening is there or if it's patent, that means open, it will go into the nasal cavity that way.

Q. This is a turbinate?

A. There's three sets of turbinates, inferior, middle and superior or supreme turbinate.

Q. All right.

A. And the purpose of the turbinates is to filter the -- help filter whatever is going inside the nose. It traps particles and it humidifies what's going into the nose.

Q. This is our nose?

A. Right, that's the opening to the nose.

Q. So when we take a breath, the air is flowing in the nose, across these turbinates and down the back of your neck?

A. Down the back of your throat into your, through your vocal cords, which are here, into your trachea and into your lungs.

And when you eat, your tongue pushes food backwards into your esophagus.

Q. So this is where the food goes and this is where the air goes?

A. Correct.

Q. And in this process, the mucus from your sinuses does produce a lot of mucus, or is there mucus being produced here as well?

A. Everybody produces a lot of mucus. It's just a matter of viscosity and how thick it is. You don't realize it, if you make mucus and you swallow it all day long, if it gets more thick.

Usually older people make more secretions,

so they notice they have to drink water or take something called mucolytic agents to break up the mucus.

But constantly, all day long what happens is the sinus -- all the sinuses make mucus, push it into the nose, the back of the throat. You swallow it, or if you're a nose blower, you blow it out your nose all the time.

Q. All right. But when it's draining up and out of the maxillary sinuses, it's coming out underneath this turbinate?

A. Correct.

Q. Doctor, what is sinusitis?

A. Well, sinusitis is an inflammation of the membranes of the sinuses.

Q. When you say the membranes, if we were to open up -- if we were to just cut this away and we could look right into the sinuses, that's what it would look like, right?

A. Well, pretty much. I mean, what happens if you take a normal sinus and you open it up or you look in it, we do it and we find normal sinuses when we operate sometimes and look around.

But when you look around in an area, a lot of times this opening is just patent, an opening, you

can look in there and see normal membranes.

Q. When you say patent?

A. Patent means open. You look in there and I'd say the sinus membrane is equivalent to taking bone and putting tissue paper on it. That's the mucosa of the sinus.

Q. Mucosa means lining?

A. Lining.

And when that lining gets real thickened, then have you sinusitis.

Q. Okay. And can you have -- are there types of sinusitis like acute and chronic?

A. Well, there's acute and chronic. And there's something in the middle called subacute sinusitis, which is not really making it to chronic sinusitis, but maybe a little bit more than acute sinusitis.

Q. And what's the difference between acute and chronic sinusitis?

A. What happens is that when somebody gets sick or you have a cold or you have allergies or for some reason you develop sinus problems and you're going to the physician and you say, you've got a problem.

Acute sinusitis is made up of symptoms.

And the symptoms you come in, you're complaining of facial fullness or pressure, swelling over the face. A lot of times there's pain to that patient. You get a fever. You get bad breath. You get a post nasal drainage. Sometimes a cough. Although kids get more coughs than adults.

You can have a drainage from the nose, either a green drainage, or sometimes with acute sinusitis you may not have any drainage because that opening is blocked. And that's why you got the sinus problem.

So those are pretty much what sinusitis -- when you bend forward it hurts and you feel the pressure in your face. Your eyes will sometimes hurt. Sometimes you get tenderness in your teeth if it's from the maxillary sinuses.

Q. Doctor, how do you diagnose chronic sinusitis? What's required to diagnose chronic sinusitis; what do you have to have to have chronic sinusitis?

A. What happens is someone comes in and is treated for a respiratory infection or something that they're calling sinusitis, which may be acute sinusitis, but for every acute sinusitis you don't treat with -- you don't get an X-ray, necessarily.

What happens is someone has symptoms consistent with it. And our guidelines for treating, usually, if the symptoms are not better in three to five days, you look inside the nose either with -- usually with a scope, and see if there's any drainage from the nose and see what this opening looks like.

Q. I have to stop you there. Because I don't think these folks have heard what a scope is.

A. We usually use a little instrument and we can just take it and look right here and we open up the nose with a little speculum. That only lets you see the very front part of the nose. Especially when the nose is congested, you see big turbinates. Sometimes you'll see clear mucus. Sometimes you'll see puss. But usually you can't see beyond this area in the nose. What has been developed are fiberoptic scopes, either a scope that you hook up to a T.V. set or you have -- hold it up to your eye and it's about this long with cable. You hook it up to a light and you can take this and actually look up into the different areas and see what's going on in that area.

Sometimes you look up and you see just membrane swelling. Other times you look up, you can see bleeding; you can see puss; you can see lesions; whatever, but that assists you in the diagnosis of

what's going on. That's also how you can come to a diagnosis of sinusitis. You look up there and you can see puss draining from one of the sinuses. You can usually tell where it's coming from. If it's coming from the back, it's sphenoid. If it's coming from the front or under the middle turbinate, it's usually the maxillary or the ethmoid sinuses. Sometimes the frontal sinus, but that's rare.

So if a patient usually doesn't get better in about three to five days, we put them on an antibiotic. Antibiotics, when you think someone has acute sinusitis, you usually treat them for 14 days to 21 days depending upon the treatment. And you decide the antibiotic based on if they've been on antibiotics before. And most of these patients will get better. The ones that don't, that come back and that you need to give antibiotics to again, then you're in the subacute period of time up until about 10 to 12 weeks.

After 10 to 12 weeks, they're still having the complaints, they're still having the symptoms. You get a CT scan and you decide whether it's really the sinusitis or if it's something masking the sinusitis and could have been something else.

Now, along that 12-week period of time

you're also treating them with decongestants, internasal steroid sprays, other things besides the antibiotics. Irrigation or saline spray.

Q. You said a CT scan, I think we have some CT scans of Ms. Janoff. And a CT scan of somebody else that you've brought with you. I don't want to get too far ahead of where we are, but I'd just like to have the jury -- which would you like?

A. Put them both up.

Q. That's Ms. Janoff?

A. And this is another patient with a problem. Remember I told you about the outflow tracks? What happens is CT scans -- this way are the best way to tell really if there's disease and if the sinuses are open. And they do the cuts every three millimeters. You start at the front and there's cut, cut, cut, cut, all the way back to the back of the sphenoid sinus.

Q. You know what, you deal with this every day. I'm willing to bet a dollar to a doughnut that that didn't register, because I barely understand it myself.

A. What happens is when these scans are done, people are lying in a machine. And the machine will take X-rays essentially from the front of your head

and reconstruct it every three millimeters going backwards.

Q. If I were to make your head be a loaf of bread, doctor --

A. It would slice it this way. So you're able to tell, and that's been shown the best way to show, if the sinuses are open. You can tell if the frontal sinuses are open, if the maxillary sinuses are open or the ethmoid or sphenoid sinuses are diseased.

Q. When you say open --

A. Patent. Well, we mean that the outflow track from the sinus into the nose is open.

Q. In other words, this area?

A. Yes.

Q. If that's open?

A. If it's blocked. You can tell if there's membrane thickening in the sinuses; therefore, it diagnoses a sinusitis. You can tell if there's tumor. You can tell a lot of different things.

So what we do usually at about --

Q. I hate to stop you in midstream, but I know how difficult it is for people to understand CT scans, anatomy. And I'd just like to take this a little slow if that's okay with you.

Can you orient these folks --

A. Well, this is pretty much this scan, but back a little bit, because it's beyond the frontal sinuses. So this one is more towards the front. And this one is back a little bit behind the frontal sinuses. And that's where the opening to --

Q. So we don't see that part?

A. What you're doing is you're seeing the ethmoid sinuses, the maxillary sinuses.

Q. With your pen, would you show us where this patient's eyes are?

A. Here, this is the eye. And you can make out pretty much the glow about right there. This also here around the eye is fat. Fat and the muscles. Those are the eyes.

Q. That's a person's forehead?

A. This is their brain. The brain and then you can see how dangerous sinus surgery can be, because you can go up into the brain when you're operating. There's a thin bone here that's about one to two millimeters thick. So it's very, very thin. And these are the maxillary sinuses here. These are the ethmoid sinuses that have air. These are some of the ethmoid sinuses here that are diseased. There's a couple of disease cells there. This is supposed to be the outflow track coming in to the nose. This is

the middle turbinate. These are the inferior turbinates.

Q. So when we look over here.

So this is what we're seeing here?

A. Correct.

This area right here is pretty much what you're seeing right there.

Q. And this is the right maxillary sinus?

A. Yes.

Q. That's the left maxillary sinus?

A. Right. And these are the ethmoid air cells that are like honeycombs. And I think it shows it better on that one.

Q. Okay. But I don't want you to mark on this one yet.

And what happens when someone has -- what are you looking for on a CT scan for making the diagnosis of chronic sinusitis? What are you looking for?

A. Well, I don't even know if this patient has chronic sinusitis, because this could just be someone with a cold, that the membranes are blocked up with in this area. And then you treat them and then sometimes you'll do a repeat scan to see if they end up needing surgery. So what you're looking for is,

see this membrane, this is the membrane that's thickened right here in this patient.

Q. Let's compare that. This is Ms. Janoff's -- her name is Suzette Ahrendt, right?

A. Correct.

Q. This was taken on October 14th, 1993, right?

A. Yes.

Q. This is just before the surgery that was performed by Dr. Stroschein and Dr. Friedland, right?

A. Correct.

Q. Can you show us -- you've said there's thickening on that CT scan, right?

A. Uh-huh.

Q. Is the same thickening present -- what color is thickening? Maybe that's a good place to start?

A. White or gray.

Q. And what is black; what does black designate?

A. Air.

Q. So whenever -- sort of the reverse of a picture?

A. Right. You can tell air is around the head and it's in the sinuses.

Q. And that air is good?

A. Right. As long as it's not in the brain.

Q. Okay. Good.

But black is?

A. Good.

Q. Black in all these areas is good and gray is not good?

A. Correct.

Q. But gray could be temporary?

A. Yes. And I don't remember on this one if it cleared or didn't clear. But this is just showing mucosal thickening.

Q. We see some gray here; what does that mean? Is that bad?

A. Well, that's the turbinate membranes that are swollen.

Q. But there's black around it. What does that mean?

A. That means there's air in the nose.

Q. There's air in the sinus?

A. In the sinuses, air in the nose.

Q. Where is that opening; where is the ostium?

A. Here. See it right there. I don't know if you want me to draw on here. And then it's up here.

Q. In that picture, in that CT scan, is the

ostium open or closed or blocked?

A. It's blocked.

Q. And would you show the jury where that is so that they know what they're looking at?

A. (Indicating.)

Q. If it's gray in that area it's blocked?

A. Correct.

Q. Can everybody see that?

If it's black in that area, like here, what does that mean?

A. It means there's air.

Now, you can hit an area that's tangential. I don't know if you understand what tangential means. But let's say you've got the wall of the sinus and you're in between cuts and you're getting the back wall of the sinus, let's say, and you have where some of the -- and you're taking a cut and it's going straight through the membrane. If it's going through the membrane, then you can see white or gray. And it's just knowing and looking at the cut before and after and knowing that you're right on the membrane in the bone.

Q. But that's not what's going on here?

A. No, this one it's all over.

Q. All right. So on this picture of

Ms. Janoff, this opening is open?

A. They're both open.

Q. That's what I mean.

A. Yes.

Q. The ostium is open on Ms. Janoff, but it's closed on that person, blocked on that person?

A. Right.

Q. So what do you look for? You said you look for thickening?

A. Well, she does have something here.

Q. What is that?

A. Well, it can be read one of two ways. I know what I think it is, but there's always a -- it could either be a small cyst on the floor of the sinus or most likely a globule of mucus, that's most likely what it is. That's why you see air bubbles in it. When you turn the head around when you're doing the scan, you tend to trap mucus that's there.

So in my experience that's a glob of mucus.

Q. Is there anything significant about a glob of mucus in the sinus?

A. No, most of us have them at different times and they can clear.

What happens, it just goes to the -- it either dissolves and goes to the opening and then the

cilia bring it around.

Q. Okay. How do people get chronic sinusitis? What causes chronic sinusitis?

A. Well, you've got to get there from acute sinusitis. You just don't jump to chronic.

Q. What causes acute sinusitis?

A. Can I sit down?

Q. Whatever would be most convenient for you. Sorry I had you standing for quite a while.

Any time you feel like you want to sit down, please do.

A. The main reason people get sinusitis is from a common cold, upper respiratory infections. You asked about sinusitis being a common disease. There's like 37 million people a year diagnosed with sinusitis; whether acute, chronic, whatever.

And they really all don't have it or I'd never be here testifying, I'd be in the operating room all day.

But what happens is patients will go to the physician and, or self-treat themselves with over-the-counter medications. And what they usually have, a common cold. And about one out of every 200 common colds results in an acute sinusitis.

So really what ends up happening is you get

a cold, you get congestion, whether it's typically a rhino virus, it's just a viral infection. You're around someone who is sick, you're in a closed environment. They cough, they sneeze, you get sick.

People -- the statistics for people getting sick, adults usually get sick two to three times a year and kids between six and eight times a year. And those illnesses will sometimes go on and they block the opening long enough where the patient will develop an infection, not get better after three to five days and then you need the antibiotics.

If you have a bacteria that's resistant to the antibiotics or you're not treated properly, you're not supposed to be given antihistamines for sinusitis, because antihistamines don't allow the sinuses to drain. So I mean you need a decongestant. Antihistamines are not great.

So what happens is, you're treated, you don't get better, goes into the subacute period of time. You're on antibiotics. Sometimes people miss work, sometimes they don't. And then you get to the point at approximately 10 to 12 weeks where you have persistent disease and you're just not getting better. And that's a chronic sinusitis.

Now, the other causes besides the upper

respiratory infections or viruses, after about five days you'll end up with a bacterial infection, or bacterial infection could have been what started it. Fungal infections can cause sinusitis. Trauma can cause sinusitis. Surgery can cause sinusitis.

Q. Do allergies cause sinusitis?

A. Allergies can cause sinusitis.

Q. How do allergies cause sinusitis? How does that happen?

A. What happens is the membrane, the opening gets blocked either with a polyp or a polypoid mucosal thickening. It's a polyp that just doesn't shrink up and go away, it persists.

Some people have attributed environmental causes.

There's genetic problems that cause sinusitis. People that have cystic fibrosis. Immuno compromised patients, patients with AIDS have a tremendous amount of sinusitis that's difficult to treat.

Q. Doctor, do -- I'll call them anatomic abnormalities.

A. Well, I didn't go into that part. But anatomic abnormalities, deviated septum can cause sinusitis by pushing on the --

Q. I hate to bring you back. But can you show the jury what you mean by these anatomic abnormalities.

A. That's one. It just doesn't cut through the whole thing.

But what happens is this is a septum, it should be straight from here to here. On a CT scan you're only getting a little cut of it, so you really can't tell which way it's going, the best way to do is with an exam, usually with the fiberoptic scope. But if you take all the X-rays and put it together you can tell one way or the other if it's blocking the opening.

Q. Where is your septum?

A. Supposed to be straight in the middle of your nasal; septum is dividing the left and right side of your nose.

Q. Is that this?

A. No, that's this underneath here, that's the septum. Some people can look and see it going one way, but if you touch right here, that's the septum. And it goes straight back to the back of the nose. The front part is cartilage and the back part is bone.

So that's what can be crooked.

Q. What happens if it's crooked? Or what can happen?

A. What usually happens is you get a stuffy nose. You get nasal congestion. And when you breathe in, the air that's supposed to go straight through back to the back doesn't. It goes in and it sort of gets in little currents and turns around and causes the nose to be sometimes even more congested. But what happens with the sinuses, it can be crooked enough that it can block one of the openings of the sinuses, or it can push the middle turbinate into that opening right here.

Now, anatomic problems, I don't know whether you've gone into one of the anatomic problems that she had or Dr. Stroschein mentioned, but is a concha bullosa. And what a concha bullosa is, it's a middle turbinate that has air trapped in it. And it's a pretty common finding. And what will happen is that can also block an opening of a sinus. It can block your breathing because it takes up space. Anything that takes up space in your nose, whether they're big turbinates inferiorly and they're swollen or a concha bullosa or if it's a deviated septum or mucus thickening from allergies block the nose in the outflow track.

Q. Doctor, in order to make a diagnosis of chronic sinusitis, what do you have to do?

A. Well, by our academy guidelines?

Q. Yes.

A. You have to have certain major and minor symptoms that are associated with, such as facial fullness, greenish nasal drainage that doesn't go away, tenderness over the face, cough, post nasal drainage, halitosis or bad breathe, fever, those types of things and then have them for a 12-week period of time, just has to be once that you have that for 12 weeks. And it's there. Or four different episodes, four different bouts of acute sinusitis in a 12-month period of time.

Q. Do you have to confirm that somehow? Do you have to confirm by radiograph --

A. Well, not really. But are you talking about acute sinusitis?

Q. No, just asking.

A. Well, the chronic sinusitis you're going to get a CT scan that shows you have the membrane thickening, the chronic sinusitis, if you have it. If you don't, then you better start working the patient up for something else.

But usually acute sinusitis, you don't

waste money and get CT scans, sometimes -- you used to go ahead and get plain film sinus series.

Q. You mean an X-ray?

A. An X-ray, four-view X-ray, front, this way and then side on both sides. And what's happened is that we all used to have these X-ray machines in our offices, but they're really not as accurate -- nearly as accurate as the CT scans. So we've -- we still will look at them and tell whether there's membrane thickening or an air fluid level. If you really have bad sinus disease and an infection in the sinus, you'll get fluid that will collect here and it layers out with gravity. It will be flat here. That's how I know this is a globule and not sitting, because it's rounded. It will be straight across.

Q. Just like a glass of water that's half full?

A. Yes.

Q. And you'll be able to see gray below and black above?

A. Yes.

Q. Doctor, can you tell this jury, what is rhinitis?

A. Rhinitis is an inflammation of the membranes inside the nose.

Q. Not in the sinus?

A. No, but terminology has changed over the past couple of years. Now we call it rhinosinusitis. You have rhinitis and you have sinusitis.

Q. What is allergic rhinitis?

A. Allergic rhinitis is membrane thickening inside the nose secondary to allergies.

Q. When you say inside the nose, you're talking about in this area, right?

A. Well, right in -- talking about the turbinates being swollen and the membranes within the nasal cavity being swollen.

Q. How do allergies cause rhinitis? How does that happen?

A. Well, when you're exposed to something that you're allergic to, the body has a response and you get edema or swelling in the tissues.

What happens is the body is telling the nose essentially, look, you're being exposed to something. This is -- your membranes swell up, they engorge with fluid into the tissues and try to almost block the nose. And if that happens enough you get little polyps that form inside the nose. Or the opening of the sinuses.

Q. All right. If you have allergic rhinitis,

can you look in the nose and see it?

A. Well, it's not going to just tell you allergic rhinitis. There are certain things when you look in the nose -- when I look in a nose, whether it's an adult or a child, you can tell whether they have allergies or not and whether to pursue something. You look in the nose, you see boggy, means real swollen membranes, usually the inferior turbinates, they look like polyps coming out and they're usually pale in coloration, sometimes they can be red. They're usually pale, boggy turbinates.

And you also have a lot of people that have nasal allergies or allergic rhinitis, do have polyps in their nose and they can have clear secretions like a glistening on the membranes that's over the nose, over the mucosa.

Q. Doctor, does secondhand smoke cause chronic sinusitis?

A. No. It's an irritant to the nose.

Q. Does secondhand smoke cause allergies?

A. No.

Q. Not an allergen?

A. Not an allergen; it's an irritant.

Q. Doctor, have you reviewed -- I think you've already reviewed Ms. Janoff's medical records?

A. Yes.

Q. Does that go all the way back to Dr. Lumry?

A. Can I take it out?

Q. Sure.

A. Because I have a summary.

Q. Go right ahead.

A. Her medical records that I have go back to pretty much when she started flying for the airline.

Q. You got some from the employment records of American Airlines, some medical records?

A. I got some medical records from the American Airlines medical records. I got some -- and I got all her doctor medical records, whether they were allergists or ENT doctors, OB/GYN, dermatologists, whatever.

Q. Doctor, does Ms. Janoff suffer from allergic rhinitis?

A. Yes.

Q. Can you tell us, looking at her records, which of her records led you to the conclusion that she has allergic rhinitis?

A. Starting with the records in -- now, you've got to understand, some of the problems, it's difficult to tell whether she has a viral infection or an allergic rhinitis when she's -- through the

years. Can I just give you an idea? Because I can't tell -- I'm not the one that's really looking at her nose at this point. I've got to rely on the records from the physicians.

Q. What year are you talking about?

A. I'm starting back in 1984.

You want just a summary?

Q. Fire away. Tell these folks.

A. I'm going to give you all the pertinent ENT/allergy findings from the beginning. And it's a period that goes from 1984 to the present time.

In 1984, December 6, 1984 she went to American Airlines, complained of blocked ears. Her left was worse than her right. And she complained about it being on descent. She was told to equalize the pressure in her ears.

From what I can tell, she didn't see a physician. She saw someone in the medical department there.

The following year, in April, April 6th of 1985 she also has a blocked right ear and complains of slight nasal congestion.

And she was told -- also she's seen by American Airlines' medical person -- she was told not to fly when she's got a cold at that point.

Not to fly when she has a head cold.

Two years later she's seen --

Q. Doctor, can I interrupt you for just one minute? I hated to do this, but when you use the word upper respiratory infection, is that a common cold?

A. Yes.

Two years later, in April of 1987, she again has a right ear blockage and she complains of sinus congestion. She sees American Airlines and another doctor, a Dr. Whiteman, who I think was a general doctor, and is put on Afrin nose sprays, Sudafed and Tavist. No X-rays are done at that point or antibiotics.

Seven months later, in November, she has core eustachian tube dysfunction, and an upper respiratory infection. And she sees her -- and she complains of some difficulty swallowing and also some congestion in her facial area. She's put on Duravent and Augmentin at that point.

And that's the first time that she's going to the -- she's going to an allergist. And that's November 23rd, 1987.

And at that time when the allergist sees her, that's really the first time that someone that's

looking in her nose that I'm going to say, quote, really knows what they're looking at at that point. The allergist sees her and sees boggy pale membranes and turbinates with minimal swelling and a runny nose and gives her a diagnosis of vasomotor irritant rhinitis. And I think a throat infection. And puts her on Duravent and Augmentin.

Wait, the previous doctor put her on Duravent and Augmentin and he continued the Augmentin and puts her on Brogfed, which is an antihistamine.

Q. Just for the jury's benefit, what is the purpose of an antihistamine?

A. Antihistamines treat allergic symptoms.

Q. What does it do for you?

A. It shrinks up the turbinates inside the nose, shrinks up the membranes that are swollen.

That's November of 1987.

At that point I believe he only saw her one time. And the patient was actually told to avoid cigarette smoke if possible.

The patient comes back, or the patient is next seen, or is sick in April of 1989. So a year and a half later she's sick.

She is seen by an ENT physician at this point. And at this time she does have sinusitis.

It's felt that she has sinusitis. But the ENT physician notices allergic changes in her nose and doesn't see any puss and puts her on penicillin. Gets an X-ray, a plain film X-ray. And it shows membrane thickening in the sinuses, in the maxillary sinuses.

Q. Where in the maxillary sinuses? Both?

A. Yes -- actually the right maxillary sinus, around that area. Just membrane thickening in that right maxillary sinus.

Q. So it would look --

A. Well, it doesn't look like that because it's plain film X-ray. I have it if you want to see it.

Q. Well, let's show it to the jury. Let's give them everything.

A. This is a copy of it.

These are the views you get. You get a view from underneath, which is this one, which pretty much tells you there's no sphenoid sinus disease. And it's really hard to tell what's going on in any of the other sinuses.

The Water's view is a view like this, which is the best one to show if there's any air fluid level.

This one, the left maxillary sinus looks a little clear. There could be a little thickening or facial swelling, but this does show the membrane thickening in the right maxillary sinus. It's not as well demonstrated as you can see on the CT scan, because it's a limited view.

This one is done straight on. It also shows you the thickening. And it shows you the big turbinates. You can see these things right here are -- I don't know if you can see from over there, but these turbinates are really swollen and they're blocking up almost all of the inferior part of the nose.

Then have you a lateral view, which sometimes will show you whether there's fluid in the sinus. And also shows you the sphenoid sinus. This is the sphenoid sinus up here. It shows you the frontal sinus and then straight through here. And you can't really tell much on this view.

But she does have symptoms and X-ray confirmation. So this is a bout of sinusitis that she has.

Q. April of '89?

A. Right.

Q. Is that an acute or chronic sinusitis?

A. No, this is an acute sinusitis.

Q. How do you know that?

A. Because the symptoms just came on a couple days before she had the X-rays.

Q. And is there a later X-ray taken?

A. In between what happens, is she's placed on penicillin and antibiotic, Clinoril. And Dr. Lanson suggests allergy tests at that time. His diagnosis is rule out sinusitis, allergic rhinitis. She has the X-ray done and she's treated with the antibiotics. She's placed on another antibiotic, Augmentin, along with steroid nasal spray. And she's seen a month later.

I don't have -- let's see. She's seen on 5-16-89 and has a normal X-ray done at that point. That X-ray I don't have.

Q. Couldn't get that.

A. Okay.

Q. So 5-16-89 she has a normal X-ray; what does that tell you?

A. But also in between, and I got this from records, I don't know how accurate it is or not, in between she apparently flies again and develops an ear infection where there's actually blood in the middle ear space from -- attributed to barotrauma.

She has that on 5-11-1989.

Q. All right.

A. So 5-16-89 she has a normal X-ray. She goes to see a different ENT physician a week later, a Dr. Weiss.

Dr. Weiss sees her and she's coming in complaining of the sinusitis. He looks at her and he feels that she has poor eustachian tube function and that she can return to work at that point.

Q. Does he treat her?

A. He gives her Seldane, which is an allergy medication back then. We don't give it now.

Q. Does he inject her turbinates?

A. Does he inject her turbinates? He doesn't inject her turbinates. What his findings were is -- his notes are pretty sloppy -- but it looks like it shows an arrow showing increased size of the turbinates.

Q. What happens next?

A. The patient starts complaining of congestion, headaches, nausea, difficulty breathing in August of 1989. And she phones her doctor and tells the doctor, I've got a sinus infection. I need an antibiotic. And at that point I don't see that an antibiotic was called in. It could have been. But

what I see is that she's placed on, or she was given some, I think Afrin nose spray.

I don't know if she got an antibiotic at that time. I don't have any records and no doctor put a note inside the chart.

The next time the patient is seen is two months later. She sees a Dr. Ben Shenson. I think he's a general practice doctor. All I have is his bill and a note from the supervisor essentially stating that she was treated for a lower respiratory tract infection and her ears were also blocked.

Q. So not something in her nose, but something down in her chest?

A. Right.

Q. A cold in her chest?

A. Yes.

The patient is next -- has a problem and goes -- next has a problem in February of 1990. She's, I think, away from home and she stubs her toe and also complains of nasal congestion. And she's placed on Afrin nasal spray. And she had already been on Ampicillin, an antibiotic, but I'm not sure why. It doesn't really tell why in the records.

And she was given Sudafed to decongest her.

Nine months later the patient goes back to

the ENT physician in October of 1990 and states that she's congested again.

Q. That's back to Dr. Weiss?

A. This is Dr. Weiss.

Dr. Weiss states that she had been on Seldane, but she's feeling better.

Q. Seldane is for?

A. For allergies.

And it says, I agree with Seldane. That's his treatment right there.

The patient is not seen again for --

Q. That's what Dr. Weiss had given her a year earlier, right, Seldane?

A. Correct. But I'm not sure if he gave it to her or if someone else did or if it was just a continuation of the prescription.

Thirteen or 14 months later the patient is first -- this is in January of 1992 is when the patient first sees Dr. Stroschein, ENT physician, who ends up operating on her.

Dr. Stroschein apparently took over for Dr. Weiss, I don't know, but they were in the same office, I don't know if he retired. But she went back to the office there.

And on Dr. Stroschein's first visit, she

states something, chief complaint, patient was on looks like Chicago International flights or something to that effect. Recurrent sinusitis, especially secondary to smoke. That was history of present illness.

The patient was placed on Tylenol Sinus and Seldane. And inside the nose were noted hyperemic boggy turbinates or mucosa, it doesn't say turbinate, said hyperemic and boggy. Hyperemic means red and swollen. Boggy means the swollen area. She writes: Examination of the oral cavity and oropharynx is cobblestoning. A lot of times when you look at the back of the throat you see little dots and that's what she's calling cobblestones. At first I thought she meant the turbinates.

Her impression is rhinitis, upper respiratory infection and her plan is Aristocort. Aristocort is -- you probably get it P O, but Aristocort here is when she got injections inside her nose or her turbinates. And that's her first treatment with Dr. Stroschein.

Q. The appearance of the inside of her nose with a hyperemic boggy appearance?

A. That's what it says.

Q. Is that consistent with allergies?

A. It can be consistent with the nose being swollen, membrane swollen. It doesn't mention any puss. It doesn't mention any polyps. Just said hyperemic boggy. I would have liked to have seen her back in 1992, '93, because that's when the important time is.

Patient is next seen by Dr. Stroschein in May of 1992. At this point when the patient is seen she complains of her ears being clogged, greenish drainage from her nose. On examination her nose has hyperemic large turbinates. Decongests well. She notes no purulence noted. No tenderness to the sinuses. None of the things that I see, just says hyperemic enlarged turbinate, decongests well, oral cavity cobblestoning. That's it.

Her impression at that time is sinusitis.

And she puts her on Amoxicillin, Beconase and Neosynephrine for three days. Now, this may be her second bout of sinusitis. She could have sinusitis or acute sinusitis at this point. But this is only the second time. So at that point she treats her. And Beconase, I didn't mention earlier, is a steroid spray used for swelling inside the nose specifically for allergies. It's a steroid spray like Flonase, Beconase, they're all the same.

The patient is treated May 4th, 1992.

The next time she comes back to Dr. Stroschein is 13 months later in July, on July 14th, 1993. She's got almost the exact same complaints at that time, light greenish drainage from her nose, she's got the boggy turbinates. She's put on Beconase and Amoxicillin.

On this one an impression is not even given, so there's no impression as to what she has.

Q. Did you have an impression?

A. She could have the beginning of acute sinusitis or she could have just had allergic rhinitis or an upper respiratory infection. But without looking at her at this time I don't know what she has, okay. It's hard to tell. She isn't cultured up until this point no cultures are done, no scoping is done.

Q. When you say not cultured, what do you mean?

A. If someone comes in with a complaint of green puss or mucus from their nose, you can look in the nose and sometimes see it. And you do a culture, you look with the scope that I'm talking about and put a Q-tip up there to find out if the Amoxicillin is the right antibiotic to choose. That's what I

mean by a culture.

The patient is next seen by Dr. Stroschein on October 14th. What happens in between is that she goes to a plastic surgeon, Dr. Friedland, who is going to do some procedures along with a procedure on her nose. He's going to fix the septum, straighten the septum and reduce the size of the inferior turbinates so she can breathe better. But what happens, either -- I don't know whether the doctor suggested it or Ms. Janoff suggested it at that time. She wanted to know whether surgery on her sinuses could be done at the same time. If she's going to be there and have all this other surgery, could she get the surgery on her sinuses, which, you know, and people, you know, quote, diagnose her with chronic sinusitis over this period of 10 years she's flying now, this is now 1993, she's been flying since 1983.

So over a period of time she's seen different doctors and they've labelled her with chronic sinusitis. But judging from what I see, there's maybe three, at the most, bouts of sinusitis. The other parts are allergies or upper respiratory infections.

But anyway, she had an X-ray in the past that showed the membrane thickening. She goes back

to Dr. Stroschein and said, look, I'm having this surgery. And Dr. Stroschein says, okay, we'll get a CT scan of the sinuses. And that's what you see right there.

Q. What does the CT scan -- I hate to have you do this since you're all set up there -- but maybe you can just -- so what does this CT scan show?

Don't do it; I'll do it for you. Just tell me what to do.

A. No.

Q. Sorry.

A. CT scan, when it's read is read as -- and what I see also is this area in the floor of the right maxillary sinus, which is either a glob of mucus or a cyst, okay.

I'm sorry. It shows openings into the nose, so that it's patent openings from the maxillary sinus into the nose. It shows big inferior turbinates and it shows this thing which is a concha bullosa. If there's further pictures backward or forwards, it does show the concha bullosa here.

So this is what the scan shows. It does not show sinusitis.

Q. Why not?

A. I don't see any membrane thickening,

there's no membrane thickening in the walls. There's no blockage of the outflow tracks. And there were no symptoms at that point, according to the patient, when she went back when Dr. Stroschein saw her again. She wasn't having symptoms. She wasn't being treated with antibiotics. She hadn't been for a while at that point.

Q. When you say the outflow tracks were open, that's the ostium?

A. Yes.

Q. Wide open?

A. They're wide open.

Q. After ten years, roughly ten years of flying and being periodically exposed to secondhand smoke on board airplanes, was her ostium open or closed?

A. It's open. And her membranes are normal as confirmed by the -- confirmed at the surgery. When Dr. Stroschein goes into those sinuses, she reports the membranes looking normal.

Q. On the operative report it says --

A. On the operative report.

Q. And do the membranes look normal on the CT scan?

A. Yes.

Q. And in the operative report in the right maxillary sinus they're described as being normal?

A. Correct. She said she removed some polyps around the opening of the sinuses. And polyps are membrane thickening associated with allergies. She said she removed some of those. And those were in the pathology report.

But there's also, understand, in the pathology report when you take out tissue, which what ended up happening is -- I'll go on to the next part when she had the surgery. She has the septum fixed, the turbinates reduced in size, but I think that's the second part of the procedure that Dr. Friedland does. But the first part is Dr. Stroschein goes up and she operates on the ethmoid sinuses, which are totally normal, the maxillary sinus opening on both sides.

She says at first she's going to do something to the concha bullosa, but on subsequent X-ray she crushes it. Normally I would take part of it out to open it up, but she crushes it, which might be acceptable. I'm not going to criticize that.

But she also does the same to this side. And removes her -- her justification for doing the ethmoidectomy were the polyps that were there.

Usually you can see polyps on the X-ray. When you go to take polyps out, as you bite it out, you also traumatize it, you bite, you take it out, blood goes to the area. So you know, any kind of pathology report is going to show inflamed membranes. And if they show normal membranes, then the pathologist isn't looking hard enough.

Q. All right. So the surgery is performed. What's the result of the surgery on the sinuses? In particular, the right maxillary sinus, what happens to it?

A. I'm sorry?

Q. In the normal healing process, what happens to the right maxillary sinus?

A. What's supposed to happen is that when we operate on sinuses, the most important thing we're doing after sinus surgery is cleaning and debriding whatever blockage or crust or whatever is going to block that track again because you don't want the person to develop sinusitis again. I don't believe she had it first, but you don't want whoever it is that you're operating on to develop the sinusitis again.

So you get them back in for several postoperative cleanings. You look up with a scope

and you get rid of anything that will block the opening of the sinuses. You rinse with saline. Some people use Afrin nose spray, but there's various ways, but it's called debridement of the area.

And she does see her several times after the surgery. Actually her second time after the surgery, the patient is not flying, but she sees her two weeks later and then another two weeks later. And at that appointment on 11-29 she does have headaches and congestion again and she's put on Amoxicillin.

MR. REILLY: This looks like a pretty good time to take a break, Your Honor.

THE COURT: It's ten minutes after 1:00, we'll be in recess until 2:15. So meet outside the courtroom at 2:15.

(Jury exits courtroom.)

THE COURT: Thank you, you may be seated.

Before we recess for the lunch, I have gone through the proposed instructions, both Plaintiff and the Defendant and I think I have them fairly well organized into what I'm going to give. The only questions I have have to do with the instructions on negligence and product liability.

Does the Plaintiff have an objection to those instructions? I don't know whether you're objecting to them. They seem appropriate to give and they weren't contained in your packet.

MR. WILLIAMS: The negligence instruction should be given because if they're going to consider negligence of American Airlines and her negligence.

THE COURT: What about the product liability instructions?

MR. WILLIAMS: The strict liability?

Where it's a defective product and I submit to you I don't think it's appropriate under this case. I think it's already been determined. I thought Your Honor ruled on those issues preliminarily before trial where we were trying to prove it was a defective product. I don't think an instruction on whether cigarette smoke or cigarettes are a dangerous product is appropriate.

THE COURT: Has that issue been resolved or just resolves it by way of a presumption?

MR. WILLIAMS: Your Honor addressed it by way of the assumption. And you quoted Judge Kaye's order. And you said I'm not going to --

I thought you said that you weren't going to deal with that issue because it was already resolved.

THE COURT: I can't really remember addressing it.

MR. WEINSTEIN: Presumption only has to do with causation not with whether the product was defective. That was Stage I.

MR. REILLY: Your Honor ruled already that nonburden shifting diseases, they still have the burden of proving all the elements of the case. So for a products liability case, which this is, they still have to prove product liability.

THE COURT: I do see the instruction proposed by the Defendant eliminated in that instruction for chronic sinusitis and only added the other Plaintiff's injuries. Would you agree that needs to be given as to those? Since I received no objections to either side, it's all guesswork, whether you're objecting to these instructions or whether you neglected to include it in your packet.

MR. HUNTER: We object to any instructions on product liability.

THE COURT: Why?

MR. HUNTER: Because that's been resolved by the settlement.

THE COURT: But only as to the enumerated.

MR. HUNTER: No, the settlement is -- it doesn't matter. The only thing that the burden relates to chronic sinusitis, but you don't give any -- you don't make me prove product liability because I've got nonburden shifting diseases.

THE COURT: I don't know. I'll have to look at the settlement agreement. I'm going to have you type this up just in case and I'll look at it again to see if I agree with that or not.

MR. WEINSTEIN: There are 26 diseases.

THE COURT: I know, but only five of them are part of the agreement.

MR. HUNTER: There's five burden shifting diseases is what Mr. Reilly said.

Judge, we argued this in front of Judge Kaye and he ruled the only thing that we needed to prove was causation and damages.

MR. REILLY: Your Honor, we've already argued this and you've already ruled on it. We argued it weeks ago and that your ruling was on nonburden shifting -- you read the settlement agreement, you read Judge Kaye's order. You

told them that they had to prove negligence, strict liability.

THE COURT: I'll go back through my notes and see if that's accurate. (In) if the event I give it, which it looks like I will.

I've combined some for the defense and some for the Plaintiff.

I'll give a copy of my rulings as to both.

Who is going to give me the clean copy of the instructions? Most of them are the Plaintiff's instructions, so I would assume it would probably be easier for you to get it.

I've included the ones, just pick them out of the Defendants' packet.

THE COURT: I only made one copy for the defense, you'll have to look at them together.

Here's what I intend to give as to the verdict form. I just made one copy per side, just share it. So I'll need a clean copy of that.

There was one other question. If I give the products liability instruction, it doesn't seem to be complete.

I know that I ruled that -- I directed a verdict as to the express -- the implied

warranty of marketability. But I don't believe I directed the verdict as to express warranty.

MR. UPSHAW: Not pled, Your Honor.

THE COURT: It's not pled? And what about strict liability.

MR. UPSHAW: Did not give a directed verdict on strict liability or negligence.

THE COURT: Then strict liability has to be included in this instruction. And it isn't that I could see.

The Defendants requested an instruction, the initial instruction, which is paragraph 1 of products liability instruction is there. And when a product is defective that goes into -- where did you get the language that's paragraph 2 of that -- of the Defendants' requested instruction number 15?

MR. MOLONY: PL 4, Your Honor.

THE COURT: PL 4. So that's paragraph number 2.

Number 16 comes from where?

MR. MOLONY: That's standard instruction 5.2, Your Honor, is number 16.

THE COURT: So there's no language here about strict liability. And when you look at

the language on strict liability, it doesn't seem to fit anyway. It would have to be reworked in some way to make it make sense.

MR. WILLIAMS: It should be modified because you should be able to claim eustachian tube, vasomotor rhinitis and those other things according to what the Court has ruled, not as to whether the cigarettes are defective, but just as to the diseases --

THE COURT: You're going to have to fix the products liability instruction. The first one is not a problem. Defendants' requested instruction number 15 is not a problem because it does specify that vasomotor rhinitis, eustachian tube, irritation of the ear, eyes, nose and throat, so it does specify those are the issues. But 16 doesn't. It just is a general instruction.

MR. MOLONY: Okay. So if I might, I'll quickly try and rework that.

THE COURT: So fix number 16.

And what else? What else of that instruction should be given? What else goes in it? Anything?

MR. WILLIAMS: Not strict liability, no,

that's PL 4, products liability number 4.

I would ask the Court if Your Honor has had a chance to review the jury instruction in the Stuart versus Hertz case because it's very applicable.

THE COURT: Why would I review that? You gave me one set, the amended set.

MR. WILLIAMS: This morning when I asked the Court if I can approach, I handed three cases in the Stuart versus Hertz instruction.

THE COURT: That one I didn't review, with the cases, because you said you weren't sure whether you were going to be asking me to give it. Depended on the testimony of Dr. Kronberg.

MR. WILLIAMS: I would request it now in light of what Dr. Kronberg said. That's a classic example.

MR. WEINSTEIN: He just blamed her for doing a surgery that wasn't necessary.

MR. REILLY: He hasn't accused her of anything.

THE COURT: I'm going to give this instruction. You can include that as well. I didn't look at it because you told me you were going to wait and see whether it was applicable.

So I will give it, so add that.

MR. MOLONY: Your Honor, if I might, if it's convenient, for clarification sake, if you would look at Defendants' requested number 16. Again, in terms of addressing the Court's concerns, I'm suggesting that in the second line where it says, "to producing the" instead of taking out diseases or conditions -- excuse me, taking out diseases or conditions and then plugging in consistent with what was included on Defendants' proposed number 15, the same reference.

THE COURT: Yes, that would be fine.

So, yes, put in the same words that were used in number 15, which is the vasomotor rhinitis, eustachian tube dysfunction, irritation of the eyes, ears, nose and throat.

MR. KODSI: Your Honor, if I may raise one more, Defendants' requested jury instruction number 5, which is the judicial notice instruction.

THE COURT: Yes.

MR. KODSI: Your Honor made some edits to number 3.

THE COURT: Yes, because I only included

damages?

MR. WILLIAMS: What is the amount of any damages caused by secondhand smoke?

THE COURT: Maybe if you put any other damages then. It sounded to me that number 5 is what you were asking for -- you were asking for total. That's how I read number 5. So there needs to be a separate -- if you're asking for damages as to pain and suffering, it has to be a separate paragraph.

MR. WEINSTEIN: Number 8.

THE COURT: Which was number 8 in Defendants.

MR. WILLIAMS: That's fine. We can go with number 8.

THE COURT: So number 8 then becomes number 4, I think. No, that becomes number 5. And then number 5 -- number 5 of yours is really number 6. So they're really out of order.

MR. WEINSTEIN: Judge, since we're on the verdict form, I would like to mention something.

MR. MOLONY: Excuse me, if we could finish that topic.

THE COURT: Yes, you understand it's a little -- I grabbed a couple of pages out of

yours and inserted into the Plaintiff.

MR. MOLONY: Your Honor, with all due respect, when you have total damages, which is what this says, if they're adopting what we had suggested, to then put this line behind it, that's redundant. Because if 5 addresses -- I don't see -- say it again. Number 5 asks for?

MR. MOLONY: Our 8 references pain and suffering. And then past and future and all the other items of damage that they've alleged, as I've understood it in this case, and it was broken down past and future. And then it directs the panel if they do award such damages to enter total damages in the right.

Now, I understood they adopted that and if they had, that should have been the end of it. But I also understood, and perhaps I misapprehended what the Court was saying, that somehow there was any remaining vitality to what had been their number 5 in their proposal. And I would suggest to the court that's redundant. It's either --

THE COURT: Here's how it looks to me, this verdict form. Number 1 they're asking, does she suffer from any of these conditions? Number 2

MR. WEINSTEIN: We agree.

MR. UPSHAW: No need for the last question.

MR. WILLIAMS: They're saying there's no need for our number 5, this one, and we agree.

THE COURT: The last one. But it says total damages, add lines 8 A and B. It should say total damages for everything. Just total damages.

MR. WILLIAMS: Or maybe add line 6 A and 6 B. Because that's a 6 now.

MR. MOLONY: Obviously we have to renumber.

MR. WEINSTEIN: Or you just say add past and future.

MR. UPSHAW: We're saying the same thing.

THE COURT: Okay. And I'm the only one that doesn't understand.

MR. MOLONY: With the Court's permission, that's a rarity.

THE COURT: There's no other damages other than pain and suffering. I get it.

MR. MOLONY: Your Honor, if I might --

THE COURT: So total damages with that in determining the total -- okay, you take out the last page.

MR. MOLONY: Your Honor, before we leave

the verdict form, one question, and I'm not going to -- apparently the Court has ruled, but I take it from the fact that you struck question number 2, the Court is not going to allow this jury to decide whether or not the burden had been met by the Plaintiff on one burden shifting disease that's involved here and that is --

THE COURT: I'm not going to ask them specifically to tell me whether they have found that or not. If they find the damages then they find that the burden was met one way or the other.

MR. UPSHAW: In that vein, I just want to make sure it's clear.

Then question 1 does not refer to chronic sinusitis.

MR. WILLIAMS: That's also true, judge, I was going to point that out.

THE COURT: It sure doesn't.

MR. WILLIAMS: We'll have to add that.

MR. UPSHAW: If you're taking out the general causation issue from the jury then you have to add that.

THE COURT: Absolutely.

MR. UPSHAW: We object to it either way

obviously.

THE COURT: And it should be the A and everything else should follow after that, I guess.

MR. WILLIAMS: Judge, doesn't the Court want that instruction to the jurors that if they answer no to all of those, then the verdict is for the Defendants then they just have to sign and date the verdict form.

THE COURT: Isn't it in there?

MR. WILLIAMS: Your Honor closed it out under 1.

MR. UPSHAW: If they answer no to number 1 all the way down, then that's it.

MR. REILLY: Got to have that one.

THE COURT: Fix that. It's going to be A through E.

MR. WILLIAMS: We'll fix that.

THE COURT: It seemed so obvious I didn't think we needed to put that paragraph in there.

MR. UPSHAW: We have to, because if you didn't give the instruction they'd just keep going and going.

MR. WEINSTEIN: Judge, now may I state that they haven't rested yet. And I have three

separate concise, right to the point -- rare indeed -- arguments that American Airlines should not be on the verdict form. Three separate arguments. I have the cases that I have to go back to the office and get, two of which I have cases to support my argument. They should not be on the verdict form. First of all --

THE COURT: Let's not hear it now. Let's have lunch. You know this goes in the packet as well. Print it up.

MR. WEINSTEIN: I'm only trying to say it may be useless to prepare the new form until you decide that.

THE COURT: Prepare it and if I don't give it, you can easily take it out. See everybody at 2:15.

MR. KODSI: One thing on the jury instructions -- want me to wait until we come back?

THE COURT: Go ahead.

MR. KODSI: On the affirmative defense instruction you adopted that was offered by the Plaintiff which talks about the comparative fault and Fabre, the only thing I'd ask this

Court is to look at Defendants' requested instruction number 9, which does the same thing.

THE COURT: I looked at every instruction.

MR. KODSI: The last three sentences of number 9 comes right out of the Fabre versus Marin case, which I would ask the Court to consider putting at the end of the second paragraph where you talk about the affirmative defense of American Airlines. It comes out of Fabre versus Marin decision about the fact that American Airlines as a party is irrelevant to their determination. Last three sentences of Defendants' number 9, I ask the Court to consider putting that back in.

THE COURT: No, I don't care if you put that in.

MR. KODSI: Last three sentences starting with "as jurors." Thanks, Your Honor.

THE COURT: So Plaintiff knows to put that in there?

MR. WILLIAMS: Yes.

THE COURT: And you'll have it in there?

MR. WILLIAMS: Yes.

MR. UPSHAW: Your Honor, we obviously, the Defendants object to the instructions --

THE COURT: That's all reserved, I have it here.

(A lunch recess was taken at 1:45 p.m.)